IN THE ABSTRACT

A quarterly newsletter from the Kentucky Cancer Registry

Large Hospital Edition May 2004

New Reporting Requirements Overview

Spring training sessions covering the Collaborative Stage and Benign CNS Tumors were held in several Kentucky locations during March and April of this year. The Collaborative Staging system will allow registrars to collect data without referring to multiple additional staging manuals. Physician-determined TNM staging will be collected in separate data fields. Allowing for an initial "learning curve", participants generally agreed that the end result will be an improvement over the current staging systems.

Reporting and abstracting rules covering the Benign CNS Tumors were covered on day two of each training session. Public Law 107-260 requires the reporting of such cases, beginning with January 1, 2004 diagnoses forward. Participants were reminded to update casefinding lists to include the ICD-9 codes for benign CNS neoplasms and tumors. In addition, pathology/autopsy reports, radiation and chemotherapy treatment logs, and neurology clinic lists must be screened for terminology associated with these newly reportable conditions. To estimate the total number of CNS cases a facility might expect to abstract in a given year, double the current number of malignant CNS cases reported annually.

The CPDMS software upgrade that includes the Collaborative Staging data elements is expected to be released at the end of this month. Hospital registrars are reminded NOT to enter patients or cancers with diagnosis dates in 2004 until the software upgrade is installed. However, the new paper Abstract Forms are ready for distribution and new CPDMS Manuals are currently being printed. The most important changes in the 2004 CPDMS Manual are:

- new reporting requirements and coding guidelines for benign and borderline brain and intracranial tumors
- the addition of Collaborative Staging data items (and the discontinuation of the SEER EOD fields: tumor size, extent of disease, pathologic extent for prostate, and lymph node involvement, as well as tumor markers. This information will now be coded in the collaborative stage data fields starting with 2004 diagnoses.)
- new guidelines for coding tumor grade
- changes in coding instructions for co-morbid conditions and palliative care
- new pages detailing the use of override flags
- a revised Appendix C, showing site group 60 for benign/borderline tumors
- a new Appendix H listing treatment agents
- a new Appendix N with guidelines for coding complex morphologies
- a new Appendix O with new Race coding guidelines and tables

The 2004 CPDMS Manuals will be distributed by the KCR Regional Coordinators as they visit to upgrade the software. If you would like an advance copy, the KCR web site will have the revised Manual available for printing after May 17, 2004.❖

NCRA's Program Recognition Committee has determined that the KCR Spring Training 2004 program supports 12.5 CE hours. Because the presentations took place in three separate locations, the event number assigned by NCRA is different for each one. Please check the listing below, and make note of the event number that corresponds to your attendance site.❖

NCRA Program Recognition for "Spring Training 2004"

Lexington KY - March 25 & 26 - **12.5 CE Hrs** - Event # **2004-029**

Elizabethtown KY - April 1 & 2 - **12.5 CE Hrs** - Event # **2004-032**

Madisonville KY - April 15 & 16 - **12.5 CE Hrs** - Event # **2004-033**

PEOPLE NEWS

New CTR: **Teresa Ford, CTR** **Mahr Cancer Center Madisonville**

New Hire: **Karen Magsig** **Baptist Hospital East Louisville**

Resignation: **Julia Simmons, CTR** **Owensboro Medical Health System Owensboro**

ACoS Cancer Program Approvals

The Mahr Cancer Center of the Regional Medical Center of Hopkins County in Madisonville underwent survey this past December. Stacy Littlepage, CTR recently received notification of full approval by the American College of Surgeons. Congratulations are extended to Stacy and Teresa Ford!

Owensboro Medical Health System received full 3-year approval with no deficiencies, following their most recent ACoS survey. Registry Supervisor and Radiation Oncology Manager JoAnn Murray relayed the good news to KCR, as their full-time registry position is currently vacant. Please accept our congratulations.❖

GOLDEN BUG AWARD!!

The following bug occurred in CPDMS version 4.60i and was first reported by Ginny Von Behren. If Survival Status was updated to 4, 5, 6, or 9 and Cause of Death was 000.0, then if an attempt was made to edit the patient data, the program would display an invalid timestamp error message and not allow the patient data to be saved. The problem could be avoided if the user exited the patient and then came back in before editing the patient data. Congratulations, Ginny, for being the first registrar to identify this golden bug! KCR programmers appreciate everyone's assistance in this area.❖

Cancer Registry Occupation in the News!

The US Department of Labor has an online publication entitled Occupational Outlook Quarterly. The Fall 2003 Volume 47, Number 3 features "You're a what? Cancer Registrar", and former NCRA president Suzanna Hoyler is the centerpiece. Read and enjoy this article about your occupation online at http://stat.bls.gov/opub/ooq/yawhat.htm.❖

Mark your calendar NOW for the 2005 NCRA Annual Conference!

Location: New Orleans, Louisiana

Date: April 10-13, 2005

Clarifying Your Spring Training 2004 Questions:

Q - What does the note on slide 71 of the Benign CNS Tumors Presentation mean? It reads "If two histologies are in the same group in Table 2, code the 1st or more specific histology."

A - If neither histology is "NOS", they are both specific; the histology that was diagnosed **first chronologically** is coded in the abstract. If one histology is "NOS", and the other histology is specific, code the **specific** histology in the abstract.

Q - What is the correct code for CS tumor size when the diagnosis is an unknown primary site (C80.9)? Page 27 of the Collaborative Staging Manual says to code '888' for unknown primaries and ill-defined sites. However, in the site specific staging section for ill-defined sites and unknown primaries (page 633), it says to use the standard table - which does **not** contain '888'.

A - Code tumor size for ill-defined and unknown primary sites as '888'. The documentation and program code for vendors shows that '888' is a valid code for this site specific schema (*per Frances Ross*).

Calendar of Events

June 3-10, 2004 - NAACCR Annual Conference
Salt Lake City, Utah

July 26 - August 6, 2004 - SEER Auditors in Kentucky

July 31, 2004 - CTR Exam Application Deadline

September 9-10, 2004 - KCR Fall Workshop
Lexington KY

September 11-25, 2004 - CTR Exam

An Answer to A Frequently Asked Question....

Q: When coding a hemicolectomy, is code 41 "Plus resection of contiguous organ" used when a small portion of ileum is submitted to pathology with a right hemicolectomy, or is 40 used if there is no involvement of the ileum? Is there a guideline for how much small bowel is removed before code 41 is used, or does there need to be involvement of the small bowel or bladder before 41 is used? (I&R question from Bernice Slone, CTR)

A: A complete right hemicolectomy requires removal of part of the terminal ileum because to remove the cecum (a part of the right colon), one has to remove the ileocecal valve and this is the origin or termination of the ileum. One does an ileotransverse colostomy for a simple right colectomy. Code 40 must include part of the terminal ileum as a requirement for the right hemicolectomy, and you do not bill extra for the ileum. However, if there are adhesions or the entire terminal ileum was removed, then 70 probably should come into play. You would discern this in the op note, because the surgeon would do it for a possible question of ileal involvement by the primary cancer. Also, the path report should indicate something more than 6" or so of ileum in the specimen. (Reply from J Milborn Jessup, MD, FACS, curator)

KCR Case Timeliness Report

- Reporting Target is 6 months from date of initial diagnosis or admission to facility
- Target percent of 2003 cases submitted by each hospital to KCR on 5/1/04 was **83.3%**

HOW TIMELY IS <u>YOUR</u> REGISTRY?

SEER CODING QUESTIONS

Please take a few moments to review these recently finalized coding questions from the SEER Inquiry System (SINQ). This is presented as an additional form of continuing education.

Question 1: How should Collaborative Stage Extension and Tumor Size be coded for benign CNS tumors?

Answer: Code CS Extension as 05 [Benign or borderline brain tumors]. Code the size of the tumor if specified; otherwise code CS Tumor Size as 999 for benign CNS benign tumors. (SINQ ID #20041002; CS Manual, Part II, pg 603)

Question 2: The patient has diffuse large B-cell lymphoma in the femur and the soft tissue of anterior chest wall, both sites biopsied. Bone marrow is negative. All the lymph nodes are negative per CT scans. What is the primary site? Lymph nodes NOS?

Answer: Code the primary site C809 [Unknown primary site]. The primary site of diffuse large B cell lymphoma can be either nodal or extranodal. The case described above is likely extranodal because there is no evidence of lymph node involvement. Since the extranodal site of origin is unknown, code to C809.
(SINQ #20041015; ICD-O-3, pg 26 (Rule D), ICD-O-3 Errata and Clarifications, pg 7 of 8)

Question 3: For a breast primary diagnosed in 2003, is lymph node involvement coded as 0 [no lymph node involvement] or 1 [micrometastasis] if isolated tumor cells (ITC) are found in an axillary lymph node?

Answer: For cases diagnosed prior to 2004, assign code 0 [No lymph node involvement] when regional lymph nodes are negative, even if there are positive isolated tumor cells (ITC). (SINQ #20041017; SEER EOD 88 3rd ed, pg 111 (January 1998)

Question 4: What is the correct histology for this lung cancer? Path report from a wedge resection says "Mod. Diff. Adenocarcinoma of scar type, intermixed w/bronchiolo-alveolar carcinoma". Is it 8250 (bronchiolo-alveolar), taking the more specific term, or 8255 (adenocarcinoma of mixed subtypes)? I know that scar type is not really a subtype of adenocarcinoma, but does adenoCa intermixed with bronchiolo-alveolar Ca code to 8255? In other words, do you have to have more than one subtype mentioned?

Answer: Code Adenocarcinoma of scar type intermixed with bronchiolo-alveolar carcinoma to 8255 [Adenocarcinoma with mixed subtypes]. This is a single tumor containing both a scar carcinoma and a bronchiolo-alveolar carcinoma - - use 8255. The synonym for 8255 is adenocarcinoma combined with other types of carcinoma (not just subtypes). (SINQ #20041023; ICD-O-3, pg 75)

Question 5: How does SEER interpret the phrase “indicative of cancer” with regard to reportability?

Answer: ”Indicative of cancer” alone is not a definitive cancer diagnosis. The word “indicative” is not on the list of ambiguous terms that constitutes a diagnosis of cancer. (SINQ #20041024; SEER Program Code Manual, 3rd ed, pg 5 (January 1998)

CANCER AWARENESS DATES

April - Cancer Control Month

May - Melanoma/Skin Cancer

June - Prostate Cancer